

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38707
State File No. 9228
Registrar's No. 9228

BIRTH NO. 17781-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY 2290	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS MO	
c. LENGTH OF STAY (In this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION 12202 VICTOR	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS 12202 VICTOR (REAR)	

3. NAME OF DECEASED (Type or Print) a. (First) LINDA b. (Middle) SUE c. (Last) KOHL		4. DATE OF DEATH (Month) (Day) (Year) OCT. 30 1950	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH MAR. 1 1950
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Mins.	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME GEORGE KOHL		13b. MOTHER'S MAIDEN NAME LUCILLE FELTS		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME GEORGE KOHL 12202 VICTOR	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Pressure due to a Congenital Hydrocephalus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 8 mos	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 752X	

22. I hereby certify that I attended the deceased from May, 1950, to Oct, 1950, that I last saw the deceased alive on 15 May, 1950, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE W. G. Muller, M.D.		23b. ADDRESS 3804 Wilmington		23c. DATE SIGNED 10-30-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov 1, 1950		24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
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DATE REC'D BY LOCAL REG. OCT 30 1950		REGISTRAR'S SIGNATURE J. B. Lasser		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis 2906 Morris		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

file 7224
1258 m

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Leof Budd
Licensed Embalmer No. **3989**

Signed
Student Embalmer

P. O. Address *St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.